CRITICAL INCIDENT RESPONSE TEAM FINAL REPORT
J.M.

November 22, 2011

Executive Summary

This is the final report to the Critical Incident Response Team (CIRT) report in this case released on April 15, 2010. This final report summarizes the work done since the release of that report.

Background: Issues Identified in Initial Report

The Critical Incident Response Team identified the following issues:

Issue #1: The need for the agency to better support the Oregon Safety Model expectation that Child Protective Services (CPS) screening is comprehensive. This includes the need to evaluate – and, as appropriate, strengthen - the sufficiency of supervisor reviews when approving CPS screening decisions.

Issue #2: The need for specific guidance to workers with respect to comprehensive assessments when children are being raised without contact by traditional community supports (school, medical, etc.).

Issue #3: The need to further investigate whether workers are systemically making a child vulnerability determination when screening child abuse reports and/or over-relying upon a child's age as part of their evaluation of child vulnerability in an assessment.

Issue #4: The need to further investigate whether the Department adequately documented all reports of abuse in this case.

Recommendation #1

The issue of the comprehensiveness of the Department's response to reports of abuse and neglect is one that has been identified in prior CIRTs. In response, the Department has again reviewed its policies, trained staff in practice and policy and begun branch-specific case reviews to identify issues and address them. Because the Department continues to struggle in this area, the CPS Program Manager has sought the assistance of the National Resource Center on Child Protective Services regarding the challenges the Department is experiencing with respect to the application of the Oregon

Safety Model expectations regarding comprehensive CPS screening and assessments and the timelines by which to complete them. The circumstances of this CIRT will be included in the work with the National Resource Center. By the end of January 2010, the National Resource Center will report back to the Department and its recommendations will be incorporated into the next CIRT report in this case. This was completed and reported in the April 15, 2010 report.

Progress Update: Below is a summary of the actions taken in response to this guidance from the NRC:

- The department worked with the National Resource Center on Organizational Improvement and the National Resource Center on Data and Technology to develop a strategic plan to support clinical supervision in Child Welfare. The plan was presented to the Assistant Director in April 2010 and to the District and Program Managers in May 2010. Although the agency has struggled developing a group to manage the Supervision Strategic Plan, several items on the plan have been accomplished, such as convening the statewide supervisors meeting and creating a field-program feedback loop using Continuous Improvement sheets. Our next steps include having this plan managed by a subgroup of the DHS Child Welfare Governance workgroup. There is similar work going on with both initiatives, and this group will be best suited to ensure that the tasks outlined in the strategic plan are carried out.

- The department implemented a new child welfare case management system called OR-Kids in August 2011. The new system will require a greater level of review and approval by supervisors. The expectation is that these mandates will require more familiarity with the Oregon Safety Model and provide enhanced opportunities for training, teaching and clinical work for supervisors, in addition to providing more accountability.

- The CPS program developed a quality assurance (QA) tool to review screening decisions and CPS assessments. To date, eight counties have been reviewed using the QA tool. CPS consultants, upon sharing the findings, worked with the local office to address practice issues that were identified. Due to the limited staff resources to continue to pull data and consultants to conduct these reviews, the CPS program has not been able to review the other counties. Once resources for sustainability of the review are identified, local offices can conduct their own quality assurance reviews.

Recommendation #2
The Department will consult with outside medical child abuse specialists to inform the Department's assessment practice when interviewing children who are being raised outside traditional community supports, such as school, medical, faith-based organizations, etc. Those experts will be asked to advise the Department on how to improve its evaluation of information both when screening and assessing calls of suspected abuse involving children who are more isolated. This consultation will be completed by March 1, 2010, and recommendations for improvement will be incorporated into the next CIRT report in this case. This was also completed and reported in the April 15, 2010 report.

Progress Update: The CPS program manager consulted with Oregon physicians who are specialists in child abuse and with the National Resource Center regarding the assessment of suspected child abuse involving children who are isolated. The NRC cautioned that isolation, by itself, does not indicate child abuse or neglect, but does increase a child's vulnerability if safety threats or concerns are present.

The department developed a practice tool based on the feedback from the NRC that will assist caseworkers to better address the issue of isolation when assessing the child's and family's level of functioning. It was anticipated that the tool would be presented and trained to at the CPS quarterly meetings. However, with the roll-out of OR-Kids in August 2011, these quarterlies have been suspended. Once they are reinstated, the CPS Program is prepared to present and facilitate practice forums on this tool. Until then, we are setting up a statewide webinar with the child welfare training unit to ensure that information is delivered to staff in a timely manner. In addition, the tool will be presented to the Program Managers and CPS consultants will introduce this tool to local CPS units. Finally, screeners and supervisors will be educated on this tool during their quarterly phone meetings. These action steps will be completed by February, 2012.

Recommendation #3
In its training for screening and assessment practice consistent with the Oregon Safety Model, the Department provides materials to staff that specifically highlight several critical determinants of vulnerability *regardless of a child's age.* Most relevant to this case, those determinants include powerlessness and non-assertiveness.

Vulnerability and the agency's identification and response to that occurred in two areas of decision-making in this case: screening of abuse reports and assessment after a report has been referred for investigation.

In the first instance, it appears that J.M.'s age was considered as a major factor in the conclusion that she was not vulnerable and, therefore, an assessment of the abuse reports was not warranted. Vulnerability is not possible to evaluate (or assess) in the screening process; assessment of vulnerability requires a face-to-face evaluation (a field assessment). In this case, when a field assessment occurred (Referral 001), it appears that J.M's age was also heavily weighted in the determination of vulnerability. While age is one consideration, as noted above, there are specific determinants that presented in this case that should have been considered irrespective of a child's age. To determine whether these are systemic issues or if these issues are unique to this case, the CIRT team will audit a representative sample of closed at screening and referral determinations where children are above the age of 10 and review specifically whether the child's age inappropriately influenced the decision that was made. That review will be completed by March 1, 2010. Depending on the outcome of that review, the CIRT Team will consider additional recommendations. The audit of cases was completed February 25, 2010, and a workgroup was convened in March 2010. However, this workgroup did not fully address the issue so another workgroup was assembled.

Progress Update: As a result, the CPS Unit coordinated and facilitated a second workgroup to review the Department's existing policy, practice and training materials regarding screening and assessments of abuse/neglect reports, and make recommendations to clarify and strengthen the Department's child protective services efforts on behalf of children and youth who are older. This workgroup consisted of stakeholders, partners and child welfare staff who have expertise working with older children and youth.

The workgroup completed its work in March 2011 and the recommendations have been posted. One of the recommendations includes the implementation of a centralized screening model to improve the consistency of practice throughout the state as it relates to screening decisions. The department is currently undertaking this initiative. The CPS Unit has been working to review, prioritize and develop a work plan to address the remaining recommendations by March 2012.

Recommendation #4
This case raises two separate issues regarding the Department's recording of and response to calls about the abuse and neglect of J.M. The first is that calls about abuse were made that were not investigated. A second concern raised is that calls may have been made but not documented. To be certain that the Department did not receive calls of abuse of neglect that it did not record, the CIRT team is recommending further investigation.

This was completed and reported in the April 15, 2010 report. The department determined that it had documented all calls made about abuse related to J.M. Each of those calls was reported on in the Initial J.M. CIRT Report. There are no further updates on this recommendation.

Purpose of Critical Incident Response Team Reports
Critical incident reports are to be used as tools for department actions when there are incidents of serious injury or death involving a child who has had contact with DHS. The reviews are launched by the Department Director to quickly analyze department actions in relation to each child. Results of the reviews are posted on the DHS Web Site. Actions are implemented based on the recommendations of the CIRT members.

The primary purpose is to review department practices and recommend improvements. Therefore, information contained in these incident reports includes information specific only to the Department's interaction with the child and family that are the subject of the CIRT Review.